

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

11203

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11173

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Penna</b> b. COUNTY <b>York</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural R#60 Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John Albert Andrew</b> Middle <b>Amsbaugh</b> Last <b></b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1895</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Molder Foundry &amp; Chain Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Penna</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>176-01-6242</b>		17. INFORMANT Address <b>Mrs. Pauline E. Bombell- 1601 Va Ave Hagerstown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crushed chest</b> DUE TO <b>Bone Deep Laceration across rt knee</b> Conditions, if any, which gave rise to immediate cause (b) <b>Closed fractured rt femur</b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Head-on automobile collision</b>					
20c. TIME OF INJURY Month, Day, Year <b>Oct. 20 19 57</b> Hour <b>4:15</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural Hagerstown Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Oct. 21, 1957</b>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>York Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant</b>		ADDRESS <b>Hagerstown, Md</b>		24a. REC'D BY REGISTRAR <b>Oct. 23, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Thomas H. Powers</b>	

RECEIVED  
OCT 28 1957  
BUREAU V. 3

RECEIVED  
OCT 28 1957  
BUREAU V. 3

11163

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MATYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN TB <b>10 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>701 E. ANTIETAM ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>LORRAINE</b> Last <b>BAKER</b>				4. DATE OF DEATH Month <b>OCT.</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>9/24/1913</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DRESS CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLAM BAKER</b>				14. MOTHER'S MAIDEN NAME <b>MARY C. REED</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>561-38-6370</b>		17. INFORMANT <b>MRS. OTTIE CRILLEY</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> <b>331x</b> DUE TO <b>Cerebral Vas. Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> (c) <b>no</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2-27-56</b> , 19__, to <b>10-7-57</b> , 19__, that I last saw the deceased alive on <b>10-7-57</b> , 19__, and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D.				ADDRESS (Street, city or town, State) <b>119 E. Antietam</b>			
DATE SIGNED <b>10-7-57</b>							
PHYSICIAN'S NAME (Type) <b>Louis G. GRAFF-M.D.</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GREENWAY CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BERKLEY SPRINGS W. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 9 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. Powers</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED: *JOHN J. SMITH*  
 SEX: *M* AGE: *45*  
 DATE OF BIRTH: *1912*

PLACE OF BIRTH: *NEW YORK*  
 OCCUPATION: *ENGINEER*

CAUSE OF DEATH: *HEART DISEASE*  
 PLACE OF DEATH: *HOME*

DATE OF DEATH: *OCT 10 1957*  
 TIME OF DEATH: *10:30 AM*

SIGNATURE OF PHYSICIAN: *[Signature]*  
 SIGNATURE OF REGISTRAR: *[Signature]*

DATE OF REGISTRATION: *OCT 10 1957*  
 TIME OF REGISTRATION: *11:00 AM*

PLACE OF REGISTRATION: *BALTIMORE*  
 OFFICE OF REGISTRATION: *101-25-2500*

DATE OF DEATH: *OCT 10 1957*  
 TIME OF DEATH: *10:30 AM*

SIGNATURE OF PHYSICIAN: *[Signature]*  
 SIGNATURE OF REGISTRAR: *[Signature]*

DATE OF REGISTRATION: *OCT 10 1957*  
 TIME OF REGISTRATION: *11:00 AM*

**RECEIVED**  
**BUREAU V. S.**  
 OCT 10 1957

11204

## CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R.F.D.</b>				c. LENGTH OF STAY IN 1b <b>2 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
f. STREET ADDRESS <b>1208 Pope Ave.,</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Welty</b> Middle <b>Baker</b> Last <b>Sr.</b>				4. DATE OF DEATH Month <b>10</b> Day <b>19</b> Year <b>57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 23, 1877</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>57</b> Min.		IF UNDER 24 HRS. Months <b>7</b> Days <b>19</b> Hours <b>57</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Furnace Tender</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Baker</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>220-05-6223</b>			
17. INFORMANT <b>Welty Baker Jr.</b>				Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> DUE TO <b>Chr. Endo Carditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4 mo.</b> (c) <b>1 week</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Feb Aug 1, 1957</b> to <b>Oct 19, 1957</b> that I last saw the deceased alive on <b>Oct 19, 1957</b> and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.				ADDRESS (Street, city or town, state) <b>Clear Spring Md</b>			
DATE SIGNED <b>10/21/57</b>							
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manor</b>		22d. LOCATION (City, town, or county) (State) <b>Tilghmanton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 25-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Leroy M. Forkner</b>				(Deputy)			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

OCT 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. E. W. Ditto, Jr. 11164 CERTIFICATE OF DEATH

Reg. Dist. No. 11176  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>30 yrs.</b>		d. STREET ADDRESS <b>870 Frederick St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>870 Frederick St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ARTHUR</b> Last <b>BARBER</b>		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Janu. 29, 1885</b>
9. AGE (In years last birthday) <b>72</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas H. Barber</b>		14. MOTHER'S MAIDEN NAME <b>Florentine Arthur</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-3638</b>	
17. INFORMANT <b>Mrs. Florentine Barber</b>		Address <b>870 Frederick St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30 hr</b> <b>10 yr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 30, 1957</b> , to <b>Oct 23, 1957</b> , that I last saw the deceased alive on <b>Oct 15, 1957</b> , and that death occurred at <b>8:17</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED, ACTUAL SIGNATURE <b>E. W. Ditto, Jr.</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-24-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>Oct. 25/1957</b>	24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>

# STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

BUREAU V. S.

OCT 28 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **062**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 2 Hancock Md</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 2 Hancock Maryland.</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																																											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Russell</b> Middle <b>Barnhart</b> Last <b>Barnhart</b>				<b>4. DATE OF DEATH</b> Month <b>10</b> Day <b>28</b> Year <b>19 57</b>																																																																																											
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4.22.1909</b>		<b>9. AGE</b> (In years last birthday) <b>48</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <b>6</b> Days <b>6</b></td> <td>Hours <b></b> Min. <b></b></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <b>6</b> Days <b>6</b>	Hours <b></b> Min. <b></b>																																																																																		
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Labor</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Orchard</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington County Md</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>																																																																																							
<b>13. FATHER'S NAME</b> <b>Harry Barnhart</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Bessie Seal</b>																																																																																											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>207-01-5999</b>		<b>17. INFORMANT</b> <b>Lillian P Eddie</b> Address <b>237 Penna.Ave Hancock Md</b>																																																																																									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Burns - Charring of head, entire body, upper and lower extremities</b>  <b>916.0</b> </td> <td rowspan="3" style="width: 15%; vertical-align: top; padding: 5px;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> <b>DUE TO</b> </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> </tr> <tr> <td colspan="3" style="padding: 5px;"> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  <b>None</b> </td> <td rowspan="2" style="vertical-align: top; padding: 5px;"> <b>19. WAS AUTOPSY PERFORMED?</b>  <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> </td> </tr> <tr> <td colspan="3" style="padding: 5px;"> <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> </td> </tr> <tr> <td colspan="3" style="padding: 5px;"> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  <b>Burned when trailer caught afire</b> </td> <td></td> </tr> <tr> <td colspan="2" style="padding: 5px;"> <b>20c. TIME OF INJURY</b> Month, Day, Year  <b>10:10 p.m. Oct. 28 1957</b> </td> <td colspan="2" style="padding: 5px;"> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> </td> <td colspan="2" style="padding: 5px;"> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>home</b> </td> <td colspan="2" style="padding: 5px;"> <b>20f. (City or town)</b> <b>Rural Hancock Wash Md</b> </td> <td colspan="2" style="padding: 5px;"> <b>(County)</b> <b></b> <b>(State)</b> <b></b> </td> </tr> <tr> <td colspan="10" style="padding: 5px;"> <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> </td> </tr> <tr> <td colspan="4" style="padding: 5px;"> <b>ACTUAL SIGNATURE</b> <i>S. Robert Wells</i> </td> <td colspan="4" style="padding: 5px;"> <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> </td> <td colspan="2" style="padding: 5px;"> <b>DATE SIGNED</b> </td> </tr> <tr> <td colspan="4" style="padding: 5px;"> <b>EXAMINER'S NAME (Type)</b> <b>S. Robert Wells, M.D.</b> </td> <td colspan="4" style="padding: 5px;"> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> </td> <td colspan="2" style="padding: 5px;"> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> </td> </tr> <tr> <td colspan="4" style="padding: 5px;"> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> </td> <td colspan="2" style="padding: 5px;"> <b>22b. DATE THEREOF</b> <b>11.3.58</b> </td> <td colspan="2" style="padding: 5px;"> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Orchard Ridge Cemetery</b> </td> <td colspan="2" style="padding: 5px;"> <b>22d. LOCATION (City, town, or county)</b> <b>Near Hancock Washington, Md.</b> </td> </tr> <tr> <td colspan="6" style="padding: 5px;"> <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Howard P. Stone</i> </td> <td colspan="2" style="padding: 5px;"> <b>ADDRESS</b> <i>Hancock Md</i> </td> <td colspan="2" style="padding: 5px;"> <b>24a. READ BY REGISTRAR</b> <i>JA Neller</i> </td> </tr> <tr> <td colspan="6" style="padding: 5px;"> <b>24b. REGISTRAR'S SIGNATURE</b> </td> <td colspan="2" style="padding: 5px;"> <b>DATE</b> <b>11/1/57</b> </td> <td colspan="2" style="padding: 5px;"> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Burns - Charring of head, entire body, upper and lower extremities</b> <b>916.0</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	<b>DUE TO</b>		<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>PART II. 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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WASHINGTON STATE DEPARTMENT OF HEALTH - DIVISION OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: 11/5/57

CAUSE OF DEATH: [illegible]

BUREAU V. S.

NOV 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Brewer

11206 CERTIFICATE OF DEATH

11178  
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown-RFD</b>				c. LENGTH OF STAY IN 1b <b>6 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Convalescent Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clearspring, Md.</b>			
d. STREET ADDRESS <b>Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>ELIZABETH</b> Last <b>BARTLE</b>				4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 20, 1863</b>	
9. AGE (In years last birthday) <b>94</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Clearspring, Wash. Co.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Peter Mouse</b>				14. MOTHER'S MAIDEN NAME <b>Mary Bear</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Ernest L. Bartle-341 Mealy Pkwy.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Dis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Clear Spring Md</b>				20g. (County) <b>Washington</b>		20h. (State) <b>Md</b>	
21. I certify that I attended the deceased from <b>Jan 1952</b> to <b>Oct 15, 1957</b> , that I last saw the deceased alive on <b>Oct 14, 1957</b> , and that death occurred at <b>6:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clear Spring Md</b> DATE SIGNED <b>10/15/57</b> ACTUAL SIGNATURE <b>David R. Brewer</b> M.D. PHYSICIAN'S NAME (Type) <b>David R. Brewer Clear Spring Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cath. Ceme.-Clearspring, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Clearspring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 17 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas H. Bowers</b>			

BUREAU V. E.

OCT 17 1957

RECEIVED

11207

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>ASHI. PRO.</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ASHI. PRO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>105 30 BALDWIN ST.</u>		d. STREET ADDRESS <u>105 30 BALDWIN ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRA VILLE I. BAUBLITZ</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>19 57</u>	
5 SEX <u>AL.</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 17, 1938</u>
9. AGE (In years last birthday) <u>19</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VARIETY STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NELSON BAUBLITZ</u>		14. MOTHER'S MAIDEN NAME <u>MARY MORAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>300-13-1045</u>	
17. INFORMANT <u>MRS. MARY L. BAUBLITZ</u>		Address <u>CLEAR SPRING, MD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u>		<u>5 MINUTES</u>
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) <u>CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION</u>		<u>2 HOURS</u>
(c) <u>CORONARY ARTERY ATHEROSCLEROSIS</u>		<u>3 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
<u>NONE</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>
20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>

21. I certify that I attended the deceased from MAY 24, 1954, to OCTOBER 15, 1957, that I last saw the deceased alive on OCTOBER 15, 1957, and that death occurred at 10-45 PM on the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE Archie Robert Cohen M.D.PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D. CLEAR SPRING, MARYLAND OCTOBER 16, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>		ADDRESS <u>Clear Spring, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>10/18/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

NOV 21 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11208

## CERTIFICATE OF DEATH

Reg. Dist. No.

11180

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Hagerstown #5				c. LENGTH OF STAY IN 1b 6 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural, Hagerstown #5				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carroll Ritchie Belew				4. DATE OF DEATH Month Day Year Oct. 28, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/9/1947	
9. AGE (In years last birthday) 10 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Waynesboro Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Claude T. Belew		14. MOTHER'S MAIDEN NAME Clara J. Lühoff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Claude T. Belew Address Hagerstown Md., #5			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis, acute - DUE TO U R I Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO Congenital Heart Lesion? (c)							INTERVAL BETWEEN ONSET AND DEATH 1-2 days 3-4 days. Brief -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 20 APRIL, 1954, to 28 OCT., 1957, that I last saw the deceased alive on 27 Oct., 1957, and that death occurred at 1:20 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Harry Hyung M.D. Blue Ridge Summit Pa 29 Oct 1957							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/57		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Brown, Waynesboro Pa.				24a. REC'D BY REGISTRAR Oct. 31, 1957		24b. REGISTRAR'S SIGNATURE Charles J. Powers	

DEAN V. S.

NOV 4 1977

NOV 4 1977

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11209 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11181

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown Legion Home</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William George Earl Bennight, Sr.</u>				4. DATE OF DEATH Month Day Year <u>Oct. 19 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11p - 1918</u>		9. AGE (in years last birthday) <u>39 yrs.</u>	IF UNDER 1 YEAR Months Days <u>9 8</u>	IF UNDER 24 HRS. Hours Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blueprint Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Okla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tollie T. Bennight</u>				14. MOTHER'S MAIDEN NAME <u>Dean Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>444-12-8672</u>		17. INFORMANT Address <u>Mrs. Wm. G. E. Bennight Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>advanced arteriosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-22-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>				22e. REC'D BY REGISTRAR <u>Oct. 25, 1957</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>N. Franklin Rouzer</u>				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>			

ACTUAL SIGNATURE S. Robert Wells

M.D. CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type) S. Robert Wells, M.D.

ASSISTANT MEDICAL EXAMINER ☐

Oct. 19 '57

DEPUTY MEDICAL EXAMINER ☒

BUREAU V. S.

OCT 28 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

## CERTIFICATE OF DEATH

Reg. Dist. No.

11186  
11324

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hancock Rest Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emory McClung Booth</b>		4. DATE OF DEATH Month Day Year <b>10 28 19 57</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9.19.1887</b>
9. AGE (In years last birthday) <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>1 9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celonese Corp</b>	
11. BIRTHPLACE (State or foreign country) <b>Fulton County Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A?</b>	
13. FATHER'S NAME <b>William Booth</b>		14. MOTHER'S MAIDEN NAME <b>Rachael Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-5342A</b>	
17. INFORMANT <b>Mrs Mary E Booth</b>		Address <b>Hancock Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mitral Stenosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-2-53</b> , 1957, to <b>10-28</b> , 1957, that I last saw the deceased alive on <b>11-25</b> , 1957, and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Herbert R. Tobias M.D.</b> <b>Herbert R. Tobias Bkely Springs, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10.30.57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fulton Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Lane Hancock Md</b>		24a. REC'D BY REGISTRAR <b>1929/57</b>	
24b. REGISTRAR'S SIGNATURE <b>J. A. Miller</b>			

BUREAU V. S.

NOV 1 1937

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11211

## CERTIFICATE OF DEATH

Reg. Dist. No.

11183

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Smithsburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Smithsburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Emory</b> Middle <b>David</b> Last <b>BOWMAN</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>24.</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23. 1897</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David E. Bowman</b>				14. MOTHER'S MAIDEN NAME <b>Julia A. Tracey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>I91-26-6840</b>		17. INFORMANT <b>Annie R. Bowman Smithsburg R.D. 1 MD</b>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>URIE MIA</b> DUE TO <b>4402</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>NEPHROSCLEROSIS</b> DUE TO <b>DISEASE</b> (c) <b>HYPERTENSIVE CARDIOVASCULAR-RENAL</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 WEEKS</b> <b>1 YEAR</b> <b>5 YEARS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>4-29-57</b> , 19 to <b>10-23-1957</b> , that I last saw the deceased alive on <b>10-23-57</b> , 19 and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11744 Mount St. Waynesboro, Va.</b> DATE SIGNED <b>10-25-57</b>							
ACTUAL SIGNATURE <b>Ross S. Finch</b> M.D.							
PHYSICIAN'S NAME (Type) <b>ROSS S. FINCH M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-27-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>near Smithsburg, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>			ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 29 '57</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 20 1957

RECEIVED

11165

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>333 Bryan Place</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
f. STREET ADDRESS <b>333 Bryan Place</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMMA</b> First Middle Last		4. DATE OF DEATH <b>October 21 1957</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 13, 1873</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>8</b>	11. IF UNDER 24 HRS Hours <b>11</b> Min <b>8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Brill</b>		14. MOTHER'S MAIDEN NAME <b>Anna Suter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-4818</b>	
17. INFORMANT <b>Mrs. Harold Fuller</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular. Eclampsia</b> <b>422.1</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Diabetes</b> (c) <b>Obesity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>12 hrs</b> <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>1957</b> , that I last saw the deceased alive on <b>1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D.		ADDRESS (Street, city or town, state) <b>119 E. Antietam St. Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Louis G. GRAFF</b>		DATE SIGNED <b>10/21/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/23/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Boyer</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct 23/1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phas H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

NOV 28 1957

BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Countersigned

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH**

Reg. Dist. No.

11185

702

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>48</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>149 King St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Low</u> Last <u>Carnochan Sr.</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1889</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Box Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Near Chillicothe Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>  </u>							
13. FATHER'S NAME <u>John A. Carnochan</u>				14. MOTHER'S MAIDEN NAME <u>Marian Low</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>705-10-7901</u>		17. INFORMANT <u>John L. Carnochan Jr.</u> Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.0 DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>unknown</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>never saw him alive</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1135 Potomac Ave. Hag. Md.</u> DATE SIGNED <u>1 Nov 57</u>							
ACTUAL SIGNATURE <u>Richard T. Binford</u>							
PHYSICIAN'S NAME (Type) <u>Richard T. Binford</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>		22b. DATE THEREOF <u>11-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich</u> ADDRESS <u>Hagerstown</u>				24a. REC'D BY REGISTRAR <u>2 Nov 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

RECEIVED

NOV 12 1957

BUREAU V. S.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 1. To the funeral director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
 2. To the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 3. To the State Board of Health, File pages 1 and 2 with the State Board of Health.  
 4. To the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11186

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Cavetown</b>		c. LENGTH OF STAY IN 1b <b>12 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stone Quarry</b>			d. STREET ADDRESS <b>68 W. Water St.</b>		
3. NAME OF DECEASED (Type or print) <b>Ronald Terry Cowan</b>			4. DATE OF DEATH <b>Oct. 13, 1957</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 25, 1935</b>		9. AGE (in years last birthday) <b>22 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>office mach. opr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>aircraft ind.</b>		11. BIRTHPLACE (State or foreign country) <b>Greencastle, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Earl O. Cowan</b>			14. MOTHER'S MAIDEN NAME <b>Ann Catherine Spessard</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Active-1957</b>		16. SOCIAL SECURITY NO. <b>214-30-1876</b>		17. INFORMANT <b>Earl O. Cowan, Smithsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull (open)</b> <b>978X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>					19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Jumped about 100 feet into stone quarry</b>			
20c. TIME OF INJURY Month, Day, Year <b>Oct. 13 19 57</b> Hour <b>9:45</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Stone Quarry</b>		20f. (City or town) (County) (State) <b>Rural Smithsburg, Wash Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>			24a. REC'D BY REGISTRAR <b>Oct 18 57</b>		
			24b. REGISTRAR'S SIGNATURE <b>Alfred</b>		

BUREAU V. S.

OCT 18 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11167

## CERTIFICATE OF DEATH

11187  
Reg. Dist. No. 302

1. PLACE OF DEATH o COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>50 yrs.</b>		d. STREET ADDRESS <b>112 Randolph Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>112 Randolph Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>LYDIA</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1871</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Keedysville, Wash. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hiram Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Gouff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-14-7014</b>	
17. INFORMANT <b>J. Franklin Davis</b>		Address <b>112 Randolph Av.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease with</b> DUE TO (b) <b>myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 years +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>max Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15</b> , 1947, to <b>18 Oct</b> , 1957, that I last saw the deceased alive on <b>18 Oct</b> , 1957, and that death occurred at <b>11:51 P.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. F. Lushy</b>		ADDRESS (Street, city or town, state) <b>230 N. Plumer St Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lushy</b>		DATE SIGNED <b>18 Oct 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-21-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>23 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Boney</b>	

BUREAU V.

OCT 23 1961

RECEIVED

11168

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Res. dence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Nursing Home</u>		d. STREET ADDRESS <u>118 W. Magnolia Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Edward Davis</u>		4. DATE OF DEATH Month Day Year <u>October 26 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leonard Davis</u>		14. MOTHER'S MAIDEN NAME <u>Emma J. Palmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>0---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. C. R. Burger</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> <u>1999</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>approx 3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/5/57</u> , 19 <u>57</u> , to <u>10/26/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/25/57</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>135 N. Potomac Hag. Md. 10/26/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. David J. Boyer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>		ADDRESS <u>Hag. Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct. 29, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1957

RECEIVED

11169

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>900 Pennsylvania Ave.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E</b> Last <b>Dodson</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christopher A. Nichols</b>				14. MOTHER'S MAIDEN NAME <b>Fannie (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>M.H. Dodson Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Day</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>10/13/57</b> , to <b>10/14/57</b> , that I last saw the deceased alive on <b>10/14/57</b> , and that death occurred at <b>9:55 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ralph E. Young M.D.</b>			ADDRESS (Street, city or town, state) <b>Williamsport, Md 10/17/57</b>				
PHYSICIAN'S NAME (Type)			DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>10-17-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>			ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct. 17, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Sheaf H. Gowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. G. LeVan

11213

## CERTIFICATE OF DEATH

Reg. Dist. No.

305

11190

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R#1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Heeder Nursing Home</b>		e. STREET ADDRESS <b>Beaver Creek</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>LESLIE</b> Last <b>DOUB</b>		4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1861</b>
9. AGE (In years last birthday) yrs. <b>96</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Beaver Creek-Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip R. Doub</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Witmer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>M. Berry Doub - Clearspring, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19 57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 17</b> , 19 <b>57</b> , to <b>Oct 31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct 30</b> , 19 <b>57</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b> DATE SIGNED <b>11/1/57</b>			
ACTUAL SIGNATURE <b>G. W. LeVan</b> M.D.		PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-2-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Beaver Creek-Wash. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>John H. Bach</b>	
24b. REGISTRAR'S SIGNATURE		DATE <b>Nov 7. 1957</b>	

BUREAU V. S.

NOV 12 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be bottled with the body prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191

## CERTIFICATE OF DEATH

Reg. Dist. No.

102

11170

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. STREET ADDRESS 20 Summit Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Bittle Entler				4. DATE OF DEATH Month Day Year Oct. 20 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1868	9. AGE (In years last birthday) 89 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor		10b. KIND OF BUSINESS OR INDUSTRY house building		11. BIRTHPLACE (State or foreign country) Shepherdstown, W.Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John P. Entler				14. MOTHER'S MAIDEN NAME Amanda Hawn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT Mrs. Irene Hook, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO general arterio-sclerosis + cerebral thrombosis + 3-4 yr. (b) DUE TO thrombosis + cerebral vasculature (c) DUE TO Accident (5 weeks) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic Hypertrophy							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 1, 1954, to Oct 20, 1957, that I last saw the deceased alive on Oct 20, 1957, and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edward W. Ditto M.D. 217 W. Washington Street 10/31/57							
ACTUAL SIGNATURE Edward W. Ditto M.D. 217 W. Washington Street							
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D. 217 W. Washington, Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-22-57		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		22d. LOCATION (City, town, or county) (State) Shepherdstown, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR Oct 23, 1957		24b. REGISTRAR'S SIGNATURE Wm. H. Lowery	

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OCT 28 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11192

11171

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>50 Yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>311 Jefferson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Franklin</b> Last <b>Favorite</b>		4. DATE OF DEATH Month <b>October</b> Day <b>14,</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1872</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months <b>85</b> Days <b>03</b> Hours <b>03</b> Min. <b>03</b>	IF UNDER 24 HRS. Hours <b>03</b> Min. <b>03</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone</b>	
11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Wash Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jack Favorite</b>		14. MOTHER'S MAIDEN NAME <b>Clara DeLosier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-0842</b>	
17. INFORMANT <b>Mrs. Mary F. Favorite-</b>		Address <b>311 Jefferson St-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Thrombosis</b> DUE TO <b>Carcinoma prostate with metastasis to rt femur</b> (b) <b>Multiple fractures of pelvic bones</b> DUE TO <b>?</b> (c) <b>71 days</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped and fell on the floor at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>4</b> P. M. <b>Aug. 4 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b>	20f. (City or town) <b>Hagerstown</b> (County) <b>Wash</b> (State) <b>Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>10-15-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-17-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hagerstown Wash Co. Md</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct 17, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Dowers</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

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OCT 21 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11172

## CERTIFICATE OF DEATH

Reg. Dist. No. 302 11193

1. PLACE OF DEATH o COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Pennsylvania</b> b COUNTY <b>Franklin</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>12 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>none</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY VIRGINIA FINAFROCK</b>				4. DATE OF DEATH Month Day Year <b>October 2 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 5, 1880</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>11 27</b>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Franklin Co., Penn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jacob Knoll</b>				14. MOTHER'S MAIDEN NAME <b>Julia Keefer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Knoll Finafrock</b>				Address <b>St. Thomas, Pennsylvania</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>							
352X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHIAL Asthma</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 1957</b> to <b>Oct 1957</b> that I last saw the deceased alive on <b>10/5/57</b> , and that death occurred at <b>9:50 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Greencastle Pa.</b>				DATE SIGNED <b>Greencastle Pa.</b>			
ACTUAL SIGNATURE <b>Bl Webster</b>				M.D.			
PHYSICIAN'S NAME (Type) <b>Bl Webster</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Norland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chambersburg, Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Rogers</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 7, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>			

BUREAU V. S.

OCT 4 1967

RECEIVED

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Dr. Hirshman, 11173 CERTIFICATE OF DEATH

11194

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 wks.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hosp.</b>				e. STREET ADDRESS <b>Antietam Drive</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HUMERICH HOUSE FISHER</b>				4. DATE OF DEATH Month Day Year <b>Oct. 11, 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 28, 1869</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>			
11. BIRTHPLACE (State or foreign country) <b>MD</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joel S. Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Louise Snyder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>unable to locate</b>			
17. INFORMANT <b>Mrs. Julia Spencer-242 E. Main St.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Westminister, Maryland</b> <b>Fibrosarcoma - Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>arteriosclerotic Heart Disease</b> DUE TO <b>several yrs.</b> (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct 18, 1947</b> , to <b>Oct 11, 1957</b> , that I last saw the deceased alive on <b>Oct 10, 1957</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St. Hagerstown Md 10/12/57</b> DATE SIGNED ACTUAL SIGNATURE <b>Philip J. Hirshman</b> M.D. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman</b> <b>159 W. Washington St.-Hagerstown</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-13-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>Oct 15, 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Phyllis Powers</b>							

BUREAU V. M.

OCT 17 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Form 222 11-4-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

11195

202

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown- rural</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gate Way Nursing Home</b>				d. STREET ADDRESS <b>28 Elizabeth St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Rhoda</b> Middle <b>MIT</b> Last <b>Fox</b>				<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>21</b> Year <b>19 57</b>				
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Oct. 12, 1868</b>		<b>9. AGE</b> (In years last birthday) yrs <b>89</b>	<b>IF UNDER 1 YEAR</b> Months <b></b> Days <b></b> Hours <b></b> Min <b></b> <b>IF UNDER 24 HRS.</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Daniel Wilhide</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elmira ( Unknown)</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Mrs. Jesse Fox</b> <b>Thurmont, Maryland</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterial Sclerotic Cardiac Dis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>10/30</b> <b>1956</b> <b>to</b> <b>10/21</b> <b>1957</b> <b>that I last saw the deceased alive on</b> <b>10/20</b> <b>1957</b> <b>and that death occurred at</b> <b>9:50 P.M.</b> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <b>David R Brewer</b> <b>M.D.</b> <b>Clear Spring</b> <b>DATE SIGNED</b> <b>10/24/57</b> <b>PHYSICIAN'S NAME (Type)</b> <b>David R Brewer</b> <b>Md.</b>								
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10-23-57</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>United Brethern Cem.</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Thurmont, Maryland</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Raymond E. Creager</b> <b>Thurmont, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> DATE <b>10-25-57</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Chas A Bowers</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

OCT 25 1957

RECEIVED

11174

CERTIFICATE OF DEATH

Reg. Dist. No. 302 11196

1 PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>243 N. Potomac Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>GEARD</b> Last <b>FRANKLIN</b>		4 DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1957</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>December 18, 1900</b>
9 AGE (In years last birthday) <b>56 yrs.</b>		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>9</b> Days <b>25</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Grocerman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own business</b>	
11 BIRTHPLACE (State or foreign country) <b>Scranton, Pa.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Isaac Franklin</b>		14 MOTHER'S MAIDEN NAME <b>Mary Devers</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>220-18-0798</b>	
17 INFORMANT <b>Mrs. Mary S. Franklin</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>705.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>arteriosclerosis</b> DUE TO (c) <b>hypertension</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>50</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>o</b> m <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1956</b> to <b>1957</b> , that I last saw the deceased alive on <b>12-12-1957</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>11/14/57</b> ACTUAL SIGNATURE <b>[Signature]</b> M D <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>[Signature]</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/17/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Episcopal Cem.</b>	22d. LOCATION (City, town or county) (State) <b>Lewisburg, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Berger</b>		24a. REC'D BY REGISTRAR <b>Oct 16, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

RECEIVED  
OCT 18 1957  
BUREAU V. S.

11175

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>55 years</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13 W. Baltimore St.,</b>			
d. STREET ADDRESS <b>13 W. Baltimore St.,</b>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>A</b> Last <b>Haines</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 18, 1864</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>W.M.R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Uniontown, Md.</b>	
13. FATHER'S NAME <b>John Haines</b>				14. MOTHER'S MAIDEN NAME <b>Mary Blacksten</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>C. Wilbur Haines</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> DUE TO <b>191X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Genital cancer</b> DUE TO <b>104m</b>						INTERVAL BETWEEN ONSET AND DEATH <b>44 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-1-57</b> , 19 <b>57</b> , to <b>10-4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10-2-57</b> , 19 <b>57</b> , and that death occurred at <b>8A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. E. Smith</b>				DATE SIGNED <b>10-4-57</b>			
PHYSICIAN'S NAME (Type) <b>A. E. Smith</b>				ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>			
24a. REC'D BY REGISTRAR <b>Oct. 7, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phed R. Bowers</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registry prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11176

11188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>4 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R # 5</b>				d. STREET ADDRESS <b>R # 5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Hause</b>				4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>19 57</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1920</b>		
9. AGE (In years last birthday) <b>37</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aircraft Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchilds</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>D. Randall Hause</b>				14. MOTHER'S MAIDEN NAME <b>Nora French</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>World War # 2 217-16-2736</b>		17. INFORMANT Address <b>Mrs. June Bowman Hause - R#5 Hagerstown, Md</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Fever</b> <b>4/4 X</b> DUE TO <b>Rheumatic Valvular heart disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>Acute Coronary occlusion</b> (c) <b>Acute Coronary occlusion</b> DUE TO <b>Acute Coronary occlusion</b> cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>13 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>none</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10-18-57		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro Penna.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Martin Poe</b>				ADDRESS <b>Waynesboro, Penna.</b>		24a. REC'D BY REGISTRAR <b>DATE 10/21/57</b>		
				24b. REGISTRAR'S SIGNATURE <b>Chas. J. Powers</b>				

RECEIVED

OCT 21 1957

BUREAU V. S.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with it. If the Board of Health, an designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15MR  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11199

Reg. Dist. No. 302

11177

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>03 Hagerstown</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>32 Summit Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>132 Summit Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Maurice F. Hickey</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1876</b>	9. AGE (In years, months, and days) <b>81 yrs</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>street dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>city of Hag.</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Peter Hickey</b>		14. MOTHER'S MAIDEN NAME <b>Johana Cuffe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>217-09-9916A</b>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vascular Hypertension</b> DUE TO <b>Acute Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (b) <b>331X</b> (c), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>None</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) <b>-</b>	(County) <b>-</b>	(State) <b>-</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>S. Robert Welle</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-1-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Welle, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11-4-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hagerstown, Md.</b>	(State) <b>-</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov 1, 1957</b>	24b. REGISTRAR'S SIGNATURE <i>Chas. H. Bowers</i>

BUREAU V. S.

NOV 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

11178

1 PLACE OF DEATH COUNTY <b>Washington</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9½ Hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		e. STREET ADDRESS <b>217 No Cannon Ave</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JOHN RAYMOND HUMMELSINE</b>		4. DATE OF DEATH Month Day Year <b>Oct 14 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 14 1890</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Md. Hagerstown Wash. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Andrew Hummelsine</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Florence-----</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>314-09-8620</b>	
17. INFORMANT <b>Mrs Lola C. Hummelsine</b>		Address <b>217 No Cannon Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Ventricular Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 ½ yrs</b> <b>4 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1949 to Oct-14, 1957</b> , that I last saw the deceased alive on <b>Oct 13, 1957</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>214 N. Potomac St. 10/14/57</b>			
ACTUAL SIGNATURE <b>E. C. L. A. Hoffman</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Hoyd A. Hoffman</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/17/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct. 17, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

RECEIVED

OCT 21 1957

BUREAU V. S.

11179

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>D. O. A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLYDE HERBERT INGRAM</u>				4. DATE OF DEATH Month Day Year <u>October 8 1957</u>			
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 18, 1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinest Sup.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing plant</u>			11. BIRTHPLACE (State or foreign country) <u>Shippensburg, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>William M. Ingram</u>				
14. MOTHER'S MAIDEN NAME <u>Anna Hendrick</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>no</u>				
16. SOCIAL SECURITY NO. <u>214-09-0326</u>			17. INFORMANT <u>Mrs. Doris Stone</u> Address <u>Hagerstown Rt. # 3, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 1957</u> to <u>Oct. 8, 1957</u> that I last saw the deceased alive on <u>Aug 10, 1957</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>10/9/57</u>							
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u>			PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Poyser</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 12 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Bowser</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, and 2 should be filed with the health department prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 15 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G222 11-4-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

11215

11202  
(353)

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md RFD</b>				c. LENGTH OF STAY IN 1b <b>6 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Convalescent Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg Maryland</b>			
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Convalescent Home</b>				g. STREET ADDRESS <b>134 East Main St.</b>			
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>JEFFERSON</b> Last <b>JACKSON</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>19</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28 1881</b>	9. AGE (In years last birthday) <b>76 76 yrs.</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>20</b> Hours <b></b> Min <b></b>	IF UNDER 24 HRS Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Victor Products</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Alburtus Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Emma Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>220-10-3634</b>		17. INFORMANT <b>Miss. Margaret Jackson</b>		Address <b>134 E. Main St. Sharpsburg Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pericarditis</b> <b>481X</b> DUE TO <b>Dissecting Aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dissecting Aneurysm</b> (c) <b>Dissecting Aneurysm</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>				20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that I attended the deceased from <b>Feb 28, 1957</b> to <b>Oct 17, 1957</b> , that I last saw the deceased alive on <b>Oct 19, 1957</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b></b>							
ACTUAL SIGNATURE <b>David R. Frewer</b> M.D. <b></b>				PHYSICIAN'S NAME (Type) <b>David R. Frewer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Samples Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert J. Frewer</b>				24a. REC'D BY REGISTRAR <b>Oct 23 - 57</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy M. Fickler</b>	

BUREAU V. S.

OCT 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11180

CERTIFICATE OF DEATH

11203

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>544 Guilford Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Jeanette</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1907</u>	
9. AGE (In years last birthday) yrs <u>50</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u></u>							
13. FATHER'S NAME <u>Harry Kountz</u>				14. MOTHER'S MAIDEN NAME <u>Eva M. Stouffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Leroy Jones</u> Address <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of thyroid with</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>52</u> , to <u>Oct 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u></u> ACTUARY SIGNATURE <u>Robert W. Campbell</u> M.D. <u>145 W. Washington St. Hagerstown Md.</u> PHYSICIAN'S NAME (Type) <u>Dr. Robert Campbell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Oct. 9, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Powers</u>			

RECEIVED

OCT 10

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11204	
11181										Reg. Dist. No. 302	
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>19 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1045 Florida Ave.</b>					d. STREET ADDRESS <b>1045 Florida Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>KEESECKER</b>					4. DATE OF DEATH Month <b>Oct.</b> Day <b>5</b> Year <b>to 7 19 57</b>						
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1883</b>		9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>unknown</b>					14. MOTHER'S MAIDEN NAME <b>unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>214-09-8378</b>		17. INFORMANT Address <b>Mrs. Marie Baughman Pheonix, Arizona</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions. If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> ; Inspection <input type="checkbox"/> ; Inquiry <input type="checkbox"/> ; and find that death resulted from: Natural causes <input checked="" type="checkbox"/> ; Accident <input type="checkbox"/> ; Suicide <input type="checkbox"/> ; Homicide <input type="checkbox"/> ; Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE _____ M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>11/9/57</b>	
EXAMINER'S NAME (Type) _____					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>10/11/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <i>R. Suter-Rouzer</i>					ADDRESS <b>Hagerstown, Md.</b>			24a. REC'D BY REGISTRAR <b>Oct 12 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Linett Bowers</i>	

RECEIVED

NOV 14 1957

RECEIVED

11182

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 352 Linganore Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elmer Benjamin Kershner		4. DATE OF DEATH Month 10 Day 27 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1868
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired laborer		10b. KIND OF BUSINESS OR INDUSTRY N.Y. Central Iron Wks Wash. Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vanlear Kershner		14. MOTHER'S MAIDEN NAME Mary Ellen Ringer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Address Ira Kershner Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Myocardial Infarction (b) Atherosclerotic Heart Disease 10 yrs (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5/57, 19, to 10/27/57, 19, that I last saw the deceased alive on 10/25/57, 19, and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
21. I certify that I attended the deceased from 3/5/57, 19, to 10/27/57, 19, that I last saw the deceased alive on 10/25/57, 19, and that death occurred at 6:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE SEARL YOUNG M.D.		HAGERSTOWN, MD 10/27/57	
PHYSICIAN'S NAME (Type) SEARL YOUNG MD		HAGERSTOWN, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE WHEREOF 10-29-57	22c. NAME OF CEMETERY OR CREMATORY Broadfording	22d. LOCATION (City, town, or county) (State) Broadfording Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fred W. Kraiss Hagerstown, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Oct. 31. 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

10

RECEIVED

11216

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>8 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Milva</u> Middle <u>Mae</u> Last <u>Kinsey</u>				4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 1873</u>	
				9. AGE (In years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Boonsboro, Md.</u>	
13. FATHER'S NAME <u>Dallas Ford</u>				14. MOTHER'S MAIDEN NAME <u>Prudence Hutzell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>no</u>		17. INFORMANT <u>Robert L. Kinsey, Smithsburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypertensive Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 22, 1957</u> to <u>Oct 23, 1957</u> that I last saw the deceased alive on <u>Oct 23, 1957</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert P. Conrad</u> M.D.				ADDRESS (Street, city or town, state) <u>137 W. Washington</u>			
PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				DATE SIGNED <u>10-25-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Smithsburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Oct 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Bost</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1957

1957 10

PLATE 1



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11217

## CERTIFICATE OF DEATH

Reg. Dist. No. 11207

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Smithburg</b>	
c. LENGTH OF STAY IN 1b <b>2 months</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Calvin</b> Middle <b>Kline</b> Last <b>Kline</b>		4. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farm owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Michael Kline</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Maugans</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Juanita Weiss, Smithburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 21, 1957</b> to <b>Oct 27, 1957</b> , that I last saw the deceased alive on <b>October 25, 1957</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. W. Livan</b>		ADDRESS (Street, city or town, state) <b>Boonsboro -</b>	
NAME (Type) <b>Dr. Gerald Livan</b>		DATE SIGNED <b>10/28/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10/30/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wolfsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co., Middletown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10/31-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mar. Katherine Dagenhart</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 1

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11208

Reg. Dist. No. 3021

11183

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN IS <b>1 hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martinsburg 85x</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Alexander Hotel Tap Room</b>				d. STREET ADDRESS <b>R # 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Leroy</b> Last <b>Lightner</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1879</b>		9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rose Dale Cemetery</b>		11. BIRTHPLACE (State or foreign country) <b>Union Bridge, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Lightner</b>				14. MOTHER'S MAIDEN NAME <b>Emma Jane Hiltabidle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-01-8555</b>		17. INFORMANT Address <b>Mrs. Jack E. Sherrad- R#3 Martinsburg, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>  <b>+ D.U.</b> DUE TO <b>Generalized Arteriosclerosis</b>  Conditions, if any, which gave rise to immediate cause (b)  (c) <b>DUE TO</b>  (c) <b>DUE TO</b>  (c) <b>DUE TO</b> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Oct. 18'57	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Dale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>R # 3 Martinsburg, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kogelschatz &amp; Coffman</b> <i>Kogelschatz &amp; Coffman</i>				ADDRESS <b>Martinsburg, W. Va.</b>		24a. REC'D BY REGISTRAR <b>Oct 24 1957</b>	
				24b. REGISTRAR'S SIGNATURE <i>W. H. H. H. H.</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

RECEIVED

OCT 28 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11218

11209

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Security Md.</u> c. LENGTH OF STAY IN 1b <u>Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Security Md</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md. RFD 6</u> d. STREET ADDRESS <u>Hagerstown, Md RFD 6</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Phyllis</u> Middle <u>Marie</u> Last <u>Malloy</u>				<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>20</u> Year <u>19 57</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan. 22 1930</u>		<b>9. AGE</b> (In years last birthday) <u>27</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>27</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Dress maker</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Ld Ailon Co.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Clearspring Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Carl Miles</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Edna Eshelman</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>218-24-9267</u>		<b>17. INFORMANT</b> <u>Mr. Robert Malloy</u> Address <u>Hagerstown, Md RFD 6</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Open Fracture skull</u> <u>DOX</u> DUE TO <u>Multiple fracture ribs</u> Conditions, if any, which gave rise to immediate cause (b) <u>Closed fracture lt. femur</u> (a), stating the underlying cause last. DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Auto- train collison</u>					
<b>20c. TIME OF INJURY</b> Hour <u>5:20</u> p. m. Month, Day, Year <u>Oct. 20 57</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>R.R. Track-Security</u>		<b>20f. (City or town)</b> <u>Rural- Hagerstown Md</u> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>S. Robert Wells, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>Oct. 21 '57</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Oct. 24-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Hagerstown, Maryland</u> (State)			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edith L. Leaf Weintraub</u> ADDRESS <u></u>				<b>24a. REC'D. BY REGISTRAR</b> <u></u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u></u>			

**RECEIVED**  
OCT 28 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

Dr. SR Wells 11184 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>4 yrs.</b>				d. STREET ADDRESS <b>1111 Salem Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1111 Salem Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN EMERSON MARTIN</b>				4. DATE OF DEATH Month Day Year <b>October 26, 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 3, 1883</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor-Penna.R.R.-Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chambersburg, Franklin</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Abraham Martin</b>			14. MOTHER'S MAIDEN NAME <b>Mary C. Ebersole</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>716-09-9418</b>		17. INFORMANT <b>Mrs. Nan C. Martin-1111 Salem Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma lymph gland of neck</b> DUE TO <b>Arteriosclerotic myocardial heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>				
20c. TIME OF INJURY Hour a. m. p. m. <b>None 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. (City or town) <b>-</b>	(County) <b>-</b>	(State) <b>-</b>		
21. I certify that I attended the deceased from <b>Dec.</b> , 19 <b>51</b> , to <b>Oct. 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct. 22</b> , 19 <b>57</b> , and that death occurred at <b>4:05 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>10-26-57</b>							
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.			115 N. Potomac Street				
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>			Hagerstown, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-28-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>Oct 30 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Lawrence</b>	

BUREAU V. S.

NOV 1 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11211

11185

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wash. Co. Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>			
f. STREET ADDRESS <u>Maugansville, md</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Menno S. Martin</u>				4. DATE OF DEATH <u>Oct 26 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/1894</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>M. INOR, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel W. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-26-7348</u>		17. INFORMANT <u>Mrs. Mary Martin - Maugansville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterior Infarcted Heart</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9-1-</u> , 1957, to <u>10-26</u> , 1957, that I last saw the deceased alive on <u>10-25</u> , 1957, and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. E. Minnich</u> M.D.				DATE SIGNED <u>10/26/57</u>			
PHYSICIAN'S NAME (Type) <u>A. E. Minnich Jr.</u>				DATE SIGNED <u>10/26/57</u>			
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>10/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leiff Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Carfords, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich - Greencastle Pa.</u>				24a. REC'D BY REGISTRAR <u>Oct 27, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shasth Bowers</u>	

BUREAU V. B.

1957

RECEIVED

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

11186

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11212

Reg. Dist. No.

382

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
f. STREET ADDRESS <b>317 S. Potomac St.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Mearl</b> Last <b>Martin</b>		4. DATE OF DEATH Month <b>10</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-1889</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchilds</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Martin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alexander</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-09-9316</b>	
17. INFORMANT <b>Charles W. Martin</b>		Address <b>Hughson, Calif.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> DUE TO <b>Generalized vascular arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b) (c) <b>DUE TO</b> (c) <b>DUE TO</b> (c) <b>DUE TO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>10-28-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-30-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brownsville</b>		22d. LOCATION (City, town, or county) (State) <b>Brownsville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct 31 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Sherry Adams</b>	

WOMEN V. S.

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RECEIVED

11187

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>ASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN TOWN <b>3 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>143 WEST FRANKLIN ST.</b>		e. STREET ADDRESS <b>809 FLORIDA AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE ELIZABETH MORGAN</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 2 1957 19</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>MARCH 10 1873</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>BOONSBORO WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN FURRY</b>		14. MOTHER'S MAIDEN NAME <b>MARY WISSINGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>809 FLORIDA AVENUE</b>		18. HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>55</b> , to <b>Oct 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct 1</b> , 19 <b>57</b> , and that death occurred at <b>4 1/2</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>318 N. Potomac ST</b> DATE SIGNED <b>10-4-57</b>			
ACTUAL SIGNATURE <b>Paul Harrison</b>		M.D. <b>318 N. Potomac ST</b>	
PHYSICIAN'S NAME (Type) <b>PAUL HARRISON</b>		<b>Hagerstown, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>OCT. 5 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH.CO.MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home</b>		ADDRESS <b>Boonshoro Md</b>	
24a. REC'D BY REGISTRAR <b>Oct 7 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Paul Harrison</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

OCT 9 1957

RECEIVED

11188

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Elmer</u> Last <u>Muritz</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 12, 1884</u>	
9. AGE (In years last birthday) yrs <u>73</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u>12</u> Min. <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>freight handler</u>		11. BIRTHPLACE (State or foreign country) <u>Liddkeburg, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Muritz</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Swisher</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>705-10-5192</u>				17. INFORMANT <u>Mrs. Effie Muritz, Smithsburg, Md 21782</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>12 years</u> <u>72 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hagerstown</u>				20g. (County) <u>Washington</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Oct. 5, 1957</u> , to <u>Oct. 16, 1957</u> that I last saw the deceased alive on <u>Oct. 16, 1957</u> , and that death occurred at <u>10:55 a.m. D.S.T.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg., Hagerstown, Md.</u>				DATE SIGNED <u>10/17/57</u>			
ACTUAL SIGNATURE <u>W. J. Layman, M.D.</u>				PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Mirnich &amp; Son, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>19/1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Shatt Bowers</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

OCT 22 1957

RECEIVED



11189

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>4 weeks</b>				d. STREET ADDRESS <b>Route #5</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDGAR</b> Last <b>MYERLY</b>				4. DATE OF DEATH Month <b>10</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 1, 1892</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b>		IF UNDER 24 HRS Hours <b>19</b> Min <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shovel Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. McKenney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-05-8676</b>		17. INFORMANT <b>Mrs. Maud L. Myerly R# 5 Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, metastatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma Bronchiogenic</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>6 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>57</b> , to <b>Oct 12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct 11</b> , 19 <b>57</b> , and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert V. H. Campbell</b>				ADDRESS (Street, city or town, state) <b>145 W Washington St Hagerstown Md.</b>		DATE SIGNED <b>10/14/57</b>	
PHYSICIAN'S NAME (Type) <b>Robert V. H. Campbell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>				ADDRESS <b>1601 Penna. Ave. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>10/14/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles H. Toward</b>			

Wm. G. Horst U-Proc.

RECEIVED

OCT 16 1957

BUREAU V. S.

## CERTIFICATE OF DEATH

00

DATE Oct 14 1953

VS A15 (4)  
15M 9/55

W. A. L. 1917

17

W. A. L. 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11220

## CERTIFICATE OF DEATH

11217

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing home</b>				d. STREET ADDRESS <b>102 Rowe St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN</b> <b>OVAC</b>				4. DATE OF DEATH Month Day Year <b>October 9 19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1875</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>7 3</b>	IF UNDER 24 HRS. Hours Min. <b>7 3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Tube miller</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cement company</b>		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-10-6908</b>		17. INFORMANT Address <b>Mrs. John Filipovitz Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4 1/2</b> (b) <b>Arteriosclerotic C V disease</b> DUE TO (c) <b>Atherosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>Unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic hypertrophy</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct 10, 1957</b> , to <b>Oct 9, 1957</b> , that I last saw the deceased alive on <b>Oct 9, 1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. L. Packard Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>145 W. Washington</b>		DATE SIGNED <b>10/10/57</b>	
PHYSICIAN'S NAME (Type) <b>L. L. Packard Jr. Hagerstown, Md.</b>							
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/11/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Hoyer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct-14-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Leroy M. Fickler</b> (Deputy)			

RECEIVED

OCT 18 1957

BUREAU V. A.

11221

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairplay R # 1</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairplay R # 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fairplay R # 1</b>		d. STREET ADDRESS <b>Fairplay R # 1</b>	
3 NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>JACKSON</b> Last <b>PAINTER</b>		4. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/27/1862</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ca binet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	11. BIRTHPLACE (State or foreign country) <b>Loudoun Co.Va.</b>
13. FATHER'S NAME <b>Joushia Painter</b>		14. MOTHER'S MAIDEN NAME <b>Louise Clipp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mr. Harold Near</b> Address <b>Fairplay, Md. Route # 1</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Labor</b> <b>1490 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug</b> , 1957, to <b>20 Oct</b> , 1957, that I last saw the deceased alive on <b>20 Oct</b> , 1957, and that death occurred at <b>3:57 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Paul Haak M.D.</b> <b>21 Oct 57</b> 28 West Potomac St. Williamsport, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/23/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>		24a REC'D BY REGISTRAR DATE <b>Oct 24 1957</b>	24b. REGISTRAR'S SIGNATURE <b>John H. Post</b>

*Wm. A. Hart v. No* Hagerstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11190

CERTIFICATE OF DEATH

Dr. J. Wilson  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>1819 Mulberry Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Glenn</u> Middle <u>Leroy</u> Last <u>Piper</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1884</u>
9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector-Pangborn-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saxton-Bedford Co. Penn.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William L. Piper</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Sheets</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOC. SEC. NO. (If yes, give war or dates of service) <u>214-09-6133</u>	
17. INFORMANT <u>Mr Paul L Piper</u>		Address <u>Pittsburgh, Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sp. city from Angerme at Leg.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Year.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hagerstown, Md.</u>	
20f. (City or town) <u>Hagerstown, Md.</u>		(County) <u>Hagerstown, Md.</u>	
(State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>Sept. 19, 1957</u> to <u>23 Oct. 1957</u> , that I last saw the deceased alive on <u>23 Oct. 1957</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>10/25/57</u>			
ACTUAL SIGNATURE <u>J. D. Wilson</u> M.D.			
PHYSICIAN'S NAME (Type) <u>J. D. WILSON, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 26, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct. 28, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Coe</u>	

RECEIVED

OCT 20 1957

BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191

## CERTIFICATE OF DEATH

11220

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last <b>KARLA MARIA QUINN</b>				4. DATE OF DEATH Month Day Year <b>October 11 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 9, 1957</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James J. Quinn</b>				14. MOTHER'S MAIDEN NAME <b>Jeanne E. Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. James J. Quinn Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>10-9-57</b> , 19___, to <b>10-11-57</b> , 19___, that I last saw the deceased alive on <b>10-11-57</b> , 19___, and that death occurred at ___ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md</b> DATE SIGNED <b>10-11-57</b> ACTUAL SIGNATURE <b>SEARLY YOUNG M.D.</b> PHYSICIAN'S NAME (Type) <b>SEARLY YOUNG M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/12/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Royer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 13 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Phyllis R. Royster</b>			

BUREAU V. S.

OCT 11 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Filed 11-14-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

11222

11221

308

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock 2</b> c. LENGTH OF STAY IN 1b <b>1Yr.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 2 Hancock Maryland.</b> d. STREET ADDRESS  e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ricky</b> Middle <b>Glenn</b> Last <b>Ray</b>		4. DATE OF DEATH Month <b>10.</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-55</b> 9. AGE (In years lost birthday) yrs <b>1</b> IF UNDER 1 YEAR <b>11</b> Mths <b>19</b> Days IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Berkeley County W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Glenn A Ray</b>		14. MOTHER'S MAIDEN NAME <b>Lucille R Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Glenn A Ray Rural 2 Hancock Maryland.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442 X</b> <b>Virius Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 da</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 25, 1957</b> to <b>Oct 25, 1957</b> that I last saw the deceased alive on <b>Oct 25, 1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hancock Md</b> DATE SIGNED <b>10/27/57</b> ACTUAL SIGNATURE <b>L.M. Shaffer</b> M.D. PHYSICIAN'S NAME (Type) <b>L.M. SHAFER M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10.28.57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Orchard Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Hancock Washington MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard F. Helton</b>		24a. REC'D BY REGISTRAR <b>DATE 10/28/57</b> 24b. REGISTRAR'S SIGNATURE <b>J. H. Neider</b>	

RECEIVED

OCT 1957

BUREAU V. S.

# CERTIFICATE OF DEATH

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

RECEIVED

OCT 16 1957

BUREAU V



11192

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN TB <b>28 years</b>				d. STREET ADDRESS <b>621 Guilford Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>621 Guilford Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RUTH</b> First <b>MARGUERITE</b> Middle <b>RICKRODE</b> Last				4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 11, 1895</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>29</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chambersburg, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Adam Crist</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Wise</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO <b>none</b>				17. INFORMANT <b>Mr. Louis Rickrode</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Cerebral Hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>8 yrs</b> <b>8 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m <b>19</b> p m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Oct 1952</b> to <b>Oct 10 1957</b> , that I last saw the deceased alive on <b>Apr 24 1957</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Therese M. Williams</b>				ADDRESS (Street, city or town, state) <b>159 W. Washington St Hagerstown Md</b>			
DATE SIGNED <b>Oct 12 1957</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/12/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Penzer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REG STRAR <b>Oct 12 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas H. Powers</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 11 1957

RECEIVED

11193 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>15 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>51 West Franklin St</b>				e. STREET ADDRESS <b>51 West Franklin St</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>BETTIE</b> Middle <b>---</b> Last <b>RUBEN</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2 1893</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houseswork</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Max Ruben</b>				14. MOTHER'S MAIDEN NAME <b>Lena Simon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or date of service) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Aaron S. Ruben 1133 Hamilton Blvd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Suspected Carcinoma of ovary.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b> <b>2 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 23</b> , 19 <b>35</b> , to <b>Oct 9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct 9</b> , 19 <b>57</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				DATE SIGNED <b>10/11/57</b>			
PHYSICIAN'S NAME (Type) <b>PHILIP J. HIRSHMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 11-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Abraham Cemetery Hagerstown Wash. Co Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Goffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Oct 11 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>			

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11194

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11225  
302  
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b> c. LENGTH OF STAY IN 1b <b>60yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>136 William Ave.</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b> d. STREET ADDRESS <b>136 William Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Curtis Henry Scott</b> First Middle Last		4. DATE OF DEATH Month <b>10</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 25 1878</b>
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	
11 BIRTHPLACE (State or foreign country) <b>Hagerstown Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George Scott</b>		14. MOTHER'S MAIDEN NAME <b>Mary Waters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Jane Scott</b>		Address <b>136 William Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive heart disease</b> (c) <b>+ hypertensive vascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Possible pneumoconiosis - of pulmonary cyst</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 1, 1955</b> to <b>Oct. 25, 1957</b> , that I last saw the deceased alive on <b>Oct 27, 1957</b> , and that death occurred at <b>9 1/2</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edward W. Ditto</b> M.D. <b>10/30/57</b>			
ACTUAL SIGNATURE <b>Edward W. Ditto</b>			
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto 111, M.D. 217 W. Washington St. Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-28-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov. 1, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Sharrt Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION

U. S. DEPARTMENT OF JUSTICE

RECEIVED  
JAN 10 1957

11195

## CERTIFICATE OF DEATH

Reg. Dist. No. 11226

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>404 Linganore Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>DAVID</b> Last <b>SHANK</b>				4. DATE OF DEATH Month <b>10</b> Day <b>16</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1906</b>		9. AGE (In years last birthday) yrs. <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milk receiving station</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willia m S.Shank</b>				14. MOTHER'S MAIDEN NAME <b>Nettie C.Carbaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-0049</b>		17. INFORMANT <b>Mrs.Herman Shank</b> Address <b>404 Linganore Ave. Hagerstown Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>Unknown.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8.1.34</b> , 19____, to <b>10.16.57</b> , 19____, that I last saw the deceased alive on <b>10.15.57</b> , 19____, and that death occurred at <b>8.30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>S. Earl Young</i> M.D.							
PHYSICIAN'S NAME (Type) <b>S.Earl Young M.D.</b>				<b>148 N.Potomac St. Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Breadfording Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Breadfording, Washington Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>				ADDRESS <b>1601 Penna. Ave. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 18 1957</b>	
				24b. REGISTRAR'S SIGNATURE <i>Shast Bowers</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 21 1957

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11227

11224

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>/ Rural Monree- R # 1 Boonsboro</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>-</b>				d. STREET ADDRESS <b>/ R # 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ralph Otho James</b> Middle <b>Shifler</b> Last <b>-</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>12</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1893</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b>	IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Boonsboro, Md R # 1</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Otho Shifler</b>				14. MOTHER'S MAIDEN NAME <b>Arbelia Doub</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b># 1</b>		17. INFORMANT Address <b>Mr. Ralph E. Shifler - Halfway, Hagerstown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation by hanging</b> <b>7 / 11 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>-</b> DUE TO (c) <b>-</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Hanged self in corn crib at home</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>6</b> <b>2030X</b> p. m. <b>Oct. 12 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Rural Boonsboro, Wash. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b> EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>10-14-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-15-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Boonsboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home Boonsboro Md.</b>				24a. REC'D BY REGISTRAR <b>DATE Oct. 15 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John W. 1328</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

RECEIVED

OCT 17 1957

BUREAU V. E.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clearspring R 1</b>				c. LENGTH OF STAY in 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Cline</b> Last <b>Shupp</b>				4. DATE OF DEATH Month <b>10</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 21, 1876</b>	
9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. Co. Md.</b>	
13. FATHER'S NAME <b>Lewis Hose</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Vandrew</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Edward Shupp</b> Address <b>Clearspring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Genital infection</b> DUE TO <b>Genital infection</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2-1-1926</b> , to <b>10-25-1957</b> , that I last saw the deceased alive on <b>10-25-57</b> , 19 <b>57</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. E. W. Dethlefs</b> M.D.				DATE SIGNED <b>10/26/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. E. W. Dethlefs</b>				ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-28-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Rural Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>Oct 30-57</b>		24b. REGISTRAR'S SIGNATURE <b>Joe W. Murray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11196

CERTIFICATE OF DEATH

11229

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>735 Dale St.</b>			
3. NAME OF DECEASED (Type or print) First <b>JEAN</b> Middle <b>MAY</b> Last <b>SISLER</b>				4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/9/41</b>	
9. AGE (In years last birthday) <b>16</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Frances E. Sisler Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Mildred May Wolfe</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mr. Frances E. Sisler R #1 Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Status Asthmaticus &amp; Grand Mal</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10/16/57</b> to <b>10/17/57</b> , that I last saw the deceased alive on <b>10/17/57</b> , 19 <b>57</b> , and that death occurred at <b>7 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ralph F. Young</b> M.D.				DATE SIGNED <b>10/18/57</b>			
PHYSICIAN'S NAME (Type) <b>Ralph F. Young M.D.</b>				ADDRESS (Street, city or town, state) <b>101 E. Potomac St. Williamsport, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Oct. 19, 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>							

BUREAU V. H.

OCT 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11230

11226

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>				c. LENGTH OF STAY IN 1b <b>23 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HIGH STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELLEN</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 2 1866</b>	
9. AGE (in years last birthday) <b>91 yrs</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEAR BOONSBORO WASH.CO.MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ANDREW W. SMITH</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH PALMER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ROY SMITH HIGH ST. BOONSBORO MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 yrs.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Oct 10</b> , 19 <b>57</b> , to <b>Oct 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct 17</b> , 19 <b>57</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. Wilevan</b>				ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b>			
PHYSICIAN'S NAME (Type) <b>G. Wilevan</b>				DATE SIGNED <b>10/19/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT. 20 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home Boonsboro Md</b>				24a. REC'D BY REGISTRAR <b>DATE Oct 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Paul</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU V. N.

NOT 28 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11231

11227

## CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u>				c. LENGTH OF STAY IN 1b <u>35 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND L. JAMESON SR.</u>				4. DATE OF DEATH Month Day Year <u>10 1 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years last birthday) yrs. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CO. DETECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT L. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>EDA RIDGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>705-10-4800R3</u>		17. INFORMANT Address <u>WOLA SMITH CLEAR SPRING MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 16, 1955</u> to <u>Oct 1, 1957</u> that I last saw the deceased alive on <u>Oct 1, 1957</u> , and that death occurred at <u>4458 M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>10/1/57</u>							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARK ROAD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>				ADDRESS <u>Clear Spring, Md</u>		24a. REC'D BY REGISTRAR DATE <u>10/7/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Leroy M. Fochler</u>			

BUREAU V. S.

OCT 11 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11228

## CERTIFICATE OF DEATH

11232

Reg. Dist. No. 300

1 PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b>				c. LENGTH OF STAY IN 1b <b>86 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>116 E. Main Street</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>116 E. Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>SWAIN</b> Last <b>SWAIN</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20</b> Year <b>19 57</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8 DATE OF BIRTH <b>March 13 1871</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b> Hours <b>Min.</b>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Clinton Swain</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Highberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16 SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>		17 INFORMANT <b>Mr. Charles Mc Graw</b> Address <b>116 E. Main St. Sharpsburg Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>480 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Influenza</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive, arteriosclerotic cardio-vascular-renal disease</b>							19. WAS AUTOPSY PERFORMED? <b>NO</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Sharpsburg, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>October 7 19 57</b> to <b>October 20 19 57</b> , that I last saw the deceased alive on <b>Oct. 20, 1957</b> and that death occurred at <b>3 A</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter M. Shealy</b>				DATE SIGNED <b>10/21/57</b>			
PHYSICIAN'S NAME (Type) <b>Walter M. Shealy M. D.</b>							
22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharpsburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Williams</b>				24a. REC'D BY REGISTRAR DATE <b>Oct 23-57</b>		24b. REGISTRAR'S SIGNATURE <b>E. J. Zogor</b>	

RECEIVED

100 2500

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film... 2 10-20-57 et

## CERTIFICATE OF DEATH

11233

Reg. Dist. No. 302

11197

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>341 N. Jonathan Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First Middle Last <b>Allison Tate</b>		4. DATE OF DEATH Month Day Year <b>Oct 17 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18 1883</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>		11. BIRTHPLACE (State or foreign country) <b>Statesville, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Abner Allison</b>				14. MOTHER'S MAIDEN NAME <b>Ruby Allison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>James Tate Hagerstown Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Voluntus of Colon</b> DUE TO <b>Rephroclerous</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour e. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 27, 1957</b> to <b>Oct 17, 1957</b> that I last saw the deceased alive on <b>Sept 16, 1957</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W Washington St Hagerstown Md</b> DATE SIGNED <b>10/19/57</b> ACTUAL SIGNATURE <b>Philip J. Hirshman</b> M.D. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b> <b>159 W. Washington St., Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 21 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr. Hagerstown Md</b>				24a. REC'D BY REGISTRAR <b>Oct 21 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>			

BUREAU V. F.

1957

RECEIVED

11198

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>4 HRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>				e. STREET ADDRESS <u>N. 8. N. MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>KIM</u> Middle <u>S.</u> Last <u>TOMS</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-27-1957</u>		9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W-ONE</u>				12. BIRTHPLACE (State or foreign country) <u>WASH. CO. HOSPITAL HAGERSTOWN MD. USA</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. FATHER'S NAME <u>KENNETH</u>				15. MOTHER'S MAIDEN NAME <u>PLANET VIRGINIA BOWARD</u>			
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)				17. SOCIAL SECURITY NO <u>NONE</u>		18. INFORMANT <u>KENNETH TOMS</u> Address <u>BOONSBORO MD</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u>							---
DUE TO <u>'162.5'</u>							---
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary atelectasis</u>							---
DUE TO (c) _____							---
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 27</u> , 19 <u>57</u> to <u>Oct. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 27</u> , 19 <u>57</u> , and that death occurred at <u>12:05A</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>148 West Washington St.</u> DATE SIGNED <u>10/28/57</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u> M. D.				PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct. 29. 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD</u>				24a. REC'D BY REGISTRAR <u>Oct. 29. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wheat Powers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081192XV1

BUREAU A. M.

OCT 24 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled out, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11235

11199

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>RD 4 - Hagerstown</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>W.</u> Middle <u>Weaver</u> Last				4. DATE OF DEATH <u>Oct 1, 1957</u> Month <u>1</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/10/1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Upton Weaver</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth C. Blair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Annie Weaver</u> Address <u>RD 4 Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/30/57</u> , 19 <u>57</u> , to <u>10/1/57</u> , that I last saw the deceased alive on <u>10/1/57</u> , 19 <u>57</u> , and that death occurred at <u>7:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D.				ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u> DATE SIGNED <u>10/3/57</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Broadfording</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munnich - Greencastle Pa.</u>				24a. REC'D BY REGISTRAR <u>Oct 3, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

BUREAU V. S.

OCT 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11229

CERTIFICATE OF DEATH

11236

Reg. Dist. No.

302

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Hagerstown</u>			
c. LENGTH OF STAY IN b. <u>5 Years</u>				d. STREET ADDRESS <u>Hagerstown R.F.D. #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown R.F.D. #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Wells</u> Last <u>Wells</u>				4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1871</u>	
9. AGE (In years last birthday) <u>86 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Small</u>			
14. MOTHER'S MAIDEN NAME <u>Rhoda Hicks</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs. William Wells</u> Address <u>Mt. View Trailer Court Hagerstown Md RFD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>10</u> Day <u>24</u> Year <u>1957</u> Hour <u>a. m.</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Frederick</u>				20g. (County) <u>Frederick</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>10/24/57</u> to <u>10/25/57</u> that I last saw the deceased alive on <u>10/25/57</u> and that death occurred at <u>4:22</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>10/26/57</u>							
ACTUAL SIGNATURE <u>Dr. J. P. Young</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. J. P. Young</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Taylor</u> ADDRESS <u>Frederick, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	

BUREAU V. S.

OCT 24 1977

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filled with information prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

## CERTIFICATE OF DEATH

11237

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>7 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
f. STREET ADDRESS <u>1480 Jefferson Blvd</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>FREDERICK</u> Last <u>WHITMER</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 22 1898</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>		IF UNDER 24 HRS Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Blower</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Neon Sign Co</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Fred J. Whitmer</u>				14. MOTHER'S MAIDEN NAME <u>Esther Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. # 1</u>				16. SOCIAL SECURITY NO. <u>220-16-3546</u>			
17. INFORMANT <u>Mrs Elizabeth S. Whitmer</u>				Address <u>1480 Jefferson Blvd Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>2 wks.</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic stenosis</u> DUE TO <u>years</u> (c) <u>decompensation</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>22</u> 19 <u>57</u> , to <u>1 Oct</u> 19 <u>57</u> , that I last saw the deceased alive on <u>1 Oct</u> 19 <u>57</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 W. Wash. High</u> DATE SIGNED <u>10/2/57</u>							
ACTUAL SIGNATURE <u>Edmund Boardman</u> M.D. <u>115 W. Wash. High</u>							
PHYSICIAN'S NAME (Type) <u>Edmund Boardman</u> <u>Hagerstown Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 3 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>			
24a. REC'D BY REGISTRAR <u>Oct 3 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Edmund Boardman</u>			

BUREAU V. E.

OCT 7 1957

RECEIVED

Dr. Ralph Young 11201 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>6 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>433 West Washington St.</b>				d. STREET ADDRESS <b>433 West Washington St.</b>			
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>RUTH</b> Last <b>WINGERD</b>				4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 23, 1886</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Wolf</b>				14. MOTHER'S MAIDEN NAME <b>Alice Saum</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Roy B. Wingerd-560 Salem Ave.-Hagersto</b>			
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Apoplexy</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>10/24/57</b> 19____ to <b>10/25/57</b> 19____, that I last saw the deceased alive on <b>10/25/57</b> 19____, and that death occurred at <b>2 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Ralph F. Young</b> M.D. <b>William A. Fort, Jr.</b> <b>10/26/57</b> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>Oct. 23, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Powers</b>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>		<p>5. Time of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Immediate cause: _____</p>		<p>9. Underlying cause: _____</p>	
<p>10. Manner of death: _____</p>		<p>11. Signature of physician: _____</p>		<p>12. Signature of registrar: _____</p>	
<p>13. Signature of informant: _____</p>		<p>14. Address of informant: _____</p>		<p>15. City and State: _____</p>	
<p>16. Date of filing: _____</p>		<p>17. File number: _____</p>		<p>18. Remarks: _____</p>	

BUREAU V. 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11202

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>1 hour</b>				d. STREET ADDRESS <b>28 E. Washington Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LYDIA</b> Last <b>WOODYATT</b>				4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 30, 1884</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>26</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Nevago, Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Marcus Leith</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Augerman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service) <b></b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Blanche Durkee Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO <b>175X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma ovary with abdominal metastasis.</b> DUE TO <b></b> (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>8 months (history)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. <b></b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b> (County) <b></b> (State) <b></b>							
21. I certify that I attended the deceased from <b>March 5</b> , 19 <b>57</b> , to <b>Oct. 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>October 23</b> , 19 <b>57</b> , and that death occurred at <b>10:15M</b> , from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg.</b> DATE SIGNED <b>10-28-57</b>							
ACTUAL SIGNATURE <b>W. Layman, M.D.</b>				M.D. <b>100 Professional Arts Bldg.</b>			
PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/29/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Boyer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REG'D BY REGISTRAR <b>Oct. 31, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Blanche Durkee</b>	

CERTIFICATE OF DEATH

NO. 100

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The text is mostly illegible due to blurriness.

BUREAU V. S.

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